Organizational Changes to Facilitate Transformation and Improve Outcomes

Improving Healthcare Outcomes: Summit IV
8-9 Nov 2006

Dorothy Smith, COL, MS
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Why not “How AMEDD Hospitals . .”

HOW VA HOSPITALS BECAME THE BEST

No longer a nation's shame, veteran care is acing competitors

By DOUGLAS WALLER

MOST PRIVATE HOSPITALS CAN only dream of the futuristic medicine Dr. Divya Shroff practices today. Outside an elderly patient's room, the attending physician gathers her residents around a wireless laptop propped on a mobile cart. Shroff accesses the patient's entire medical history—a stack of paper in most private hospitals. And instead of trekking to the radiology lab to view the latest X-ray, she brings it up on her computer screen. While Shroff is visiting the patient, a resident types in a request for pain medication, then punches the SEND button. Seconds later, the printer in the hospital pharmacy spits out the order. The druggist stuffs a plastic bag of pills into what looks like a tiny space capsule, then shoots it up to the ward in a vacuum tube. By the time Shroff wheels away her computer, a nurse walks up with the drugs.

Life in a big-name institution like the Mayo Clinic? Not hardly. Shroff, 31, a specialist in internal medicine, works at the Veterans Affairs hospital in Washington, where the vets who come for the cutting-edge treatment are mostly poor.

If you're surprised, that's understandable. Until the early 1990s, care at VA hospitals was so substandard that Congress considered shutting down the entire system and giving ex-G.I.s vouchers for treatment at private facilities. Today it's a very different story. The VA runs the largest integrated health-care system in the country, with more than 1,400 hospitals, clinics and nursing homes employing 14,800 doctors and 61,000 nurses. And by a number of measures, this government-managed health-care program—socialized medicine on a small scale—is beating the marketplace. For the sixth year in a row, VA hospitals last year scored higher than private facilities on the University of Michigan's American Customer Satisfaction Index, based on patient surveys on the quality of care received. The VA scored 83 out of 100; private institutions, 71. Males 65 years and older receiving VA care had about a 40% lower risk of death than those enrolled in Medicare Advantage, whose care is provided through private health plans or HMOs, according to a study published in the April edition of *Medical Care*. Harvard University just gave the VA its Innovations in American Government Award for the agency's work in computerizing patient records.

And all that was achieved at a relatively low cost. In the past 10 years, the number of veterans receiving treatment from the VA has more than doubled, from 2.5 million to 5.3 million, but the agency has cared for them with 10,000 fewer employees. The VA's cost per patient has remained steady during the past 10 years. The cost of private care has jumped about 40% in that same period.

Vets still gripe about wading through red tape for treatment. Some 11,000 have been waiting 30 days or more for their first appointment. The Iraq and Afghanistan wars could stress the system, although for the moment VA officials say the agency can accommodate the new patients. That's because older vets, especially those from the World War II and Korean War eras, are dying of natural causes at the rate of about 600,000 a year, whereas the Iraq and Afghanistan wars have so far created a little more than 550,000 new vets.

On the other hand, because advances in body armor and field medicine have enabled soldiers to survive battlefield injuries that in earlier conflicts meant death, many of the new patients are arriving at VA hospitals with severe wounds. In response, the VA has set up four polytrauma centers around the country. Dawn Halfaker, a former Army captain who lost her right arm in Iraq, says negotiating the bureaucracy to get treatment for all her medical needs has been frustrating at times. She had to wait eight months for an appointment at the Washington hospital to get her teeth cleaned. Even so, she says, the care "is not as bad as I thought it would be."

The roots of the VA's reformation go back to 1994, when Bill Clinton appointed Kenneth Kizer, a hard-charging doctor and former Navy diver, as the VA's under secretary for health. Kizer decentralized the VA's cumbersome health bureaucracy and held regional managers more accountable. Patient records were transferred to a system-wide computer network, which has made its way into only 3% of private hospitals. When a veteran is treated, the doctor has the vet's complete medical history on a laptop. In the private sector, 20% of all lab tests are needlessly repeated because the doctor doesn't have handy the results of the same test performed earlier, according to a 2004 report by the President's information technology advisory committee.

Another innovation at the VA was a bar-code system, as in the supermarket, for prescriptions—a system used in fewer than 5% of private hospitals. With a handheld laser reader, a nurse scans the bar code on a patient's wristband, then the one on the bottle of pills. If the pills don't match the prescription the doctor typed into the computer, the laptop alerts the nurse. The Institute of Medicine estimates that 1.5 million patients are harmed each year by medication errors, but computer records and bar-code scanners have virtually eliminated those problems in VA hospitals.

Private hospitals, which make their money treating people who come to them sick, don't profit from heavy investments in preventive care, which keeps patients healthy. But the VA, which is funded by tax dollars, "has its patients for life," notes Kizer, who served in his post until 1999. So to keep government spending down, "it makes economic sense to keep them healthy and out of the hospital." Kizer eliminated more than half the system's 52,000 hospital beds and plowed the money saved into opening 300 new community clinics so vets could have easier access to family-practice-style doctors. He set strict performance standards that graded physicians on health promotion.

As the reforms produced results, veterans began "voting with their feet," says Dr. Jonathan Perlin, who just resigned as the VA's health under secretary. Hundreds of thousands abandoned private physicians and enrolled in the lower-cost and higher-quality VA care. But that created a new problem. The VA's budget from Congress (currently about $30 billion annually) couldn't cover the influx. By January 2003, with hundreds of thousands waiting six months or more for their first appointment, the VA began limiting access to only vets with service-related injuries or illness or those with low income.

Veterans' groups understandably want the health-care system expanded to accommodate vets with higher incomes and no service-related ailments. Tom Bock, commander of the American Legion, has another idea: allow elderly vets not in the system who are drawing Medicare payments to spend those benefits at a VA facility instead of going to a private doctor, as is now required by Medicare. "It's a win-win-win situation," he argues. Medicare, which pays more than $6,500 per patient annually for care by private doctors, could save with the VA's less expensive care, which costs about $5,000 per patient. The vets would receive better service at the VA's facilities, which could treat millions more patients with Medicare's cash infusion.

But conservatives fear such an arrangement would be a Trojan horse, setting up an even larger national health-care program and taking more business from the private sector. Congress has no plans to enlarge the scope of veterans' health care—much less consider it a model for, say, a government-run system serving nonvets. But it's becoming more and more "ideologically inconvenient for some to have such a stellar health-delivery system being run by the government," says Margaret O'Kane, president of the National Committee for Quality Assurance, which rates health plans for businesses and individuals. If VA health care continues to be the industry leader, it may become more difficult to argue that the market can do better. ■

ACCURACY In Washington, a VA patient gets a bar-code scan

ACCESS On a laptop, a nurse can call up any patient record

RECORDS Dr. Shroff shows a patient a picture of his esophagus

SPEED Drugs are loaded into a pneumatic tube and sent to a ward

Organization of Excellence

- How do we manage the data at hand?
  - Data invisible to leadership (stovepipe discussions)
  - Monitoring natural history or random variation
  - Presenting actionable data at every level
  - Willingness to stop doing things (e.g., DQMCP)

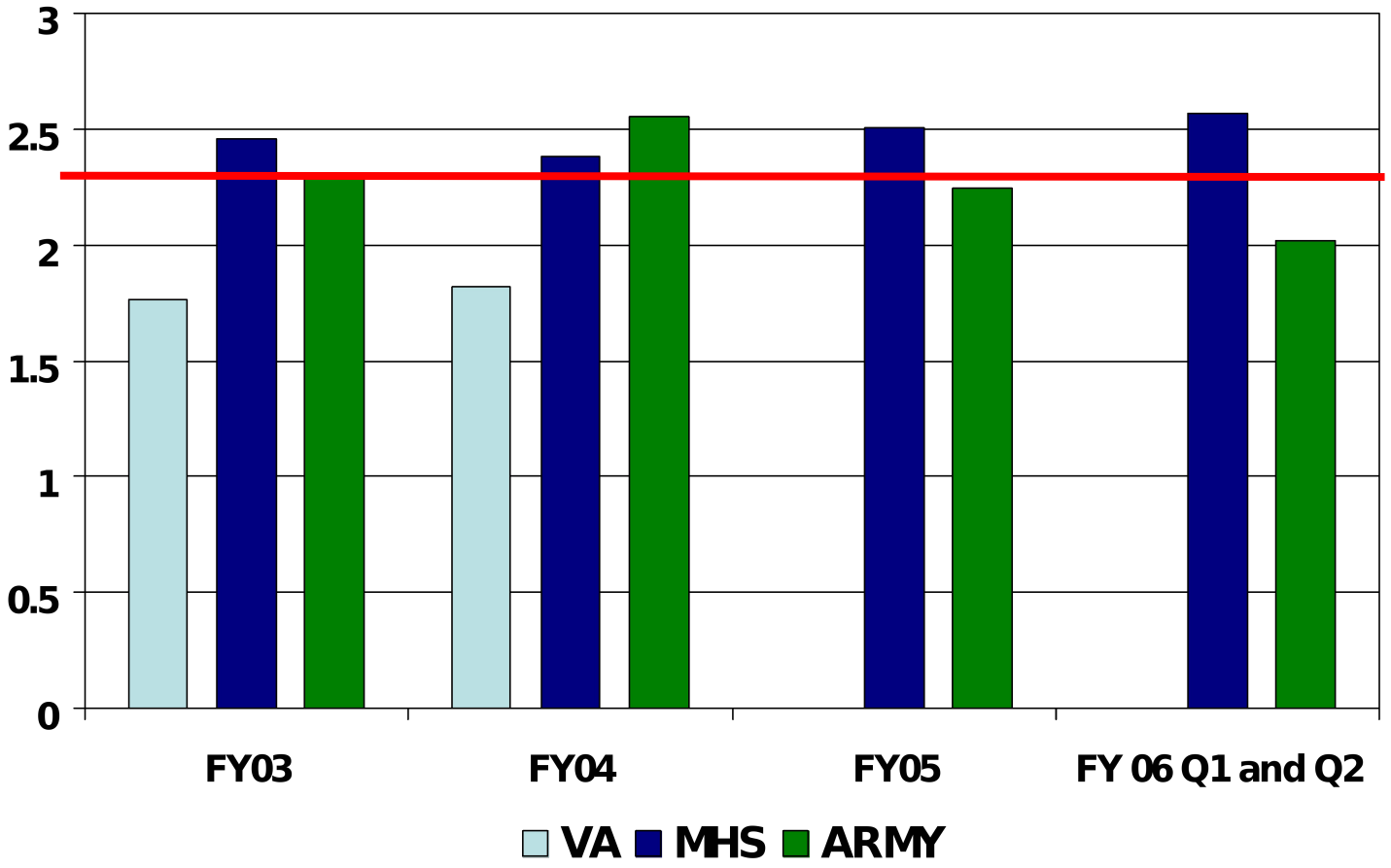
- How do we reward desired behaviors?
  - Reward desired behaviors early and repetitively and celebrate along the way

- Transition to profiling the healthcare system, not simply the individual

- “Delight” vs. satisfaction

PSI 3: Decubitus Ulcer

(Risk Adjusted Rate per 100 Discharges)



Protected under 10 USC 1102

2003 National Benchma

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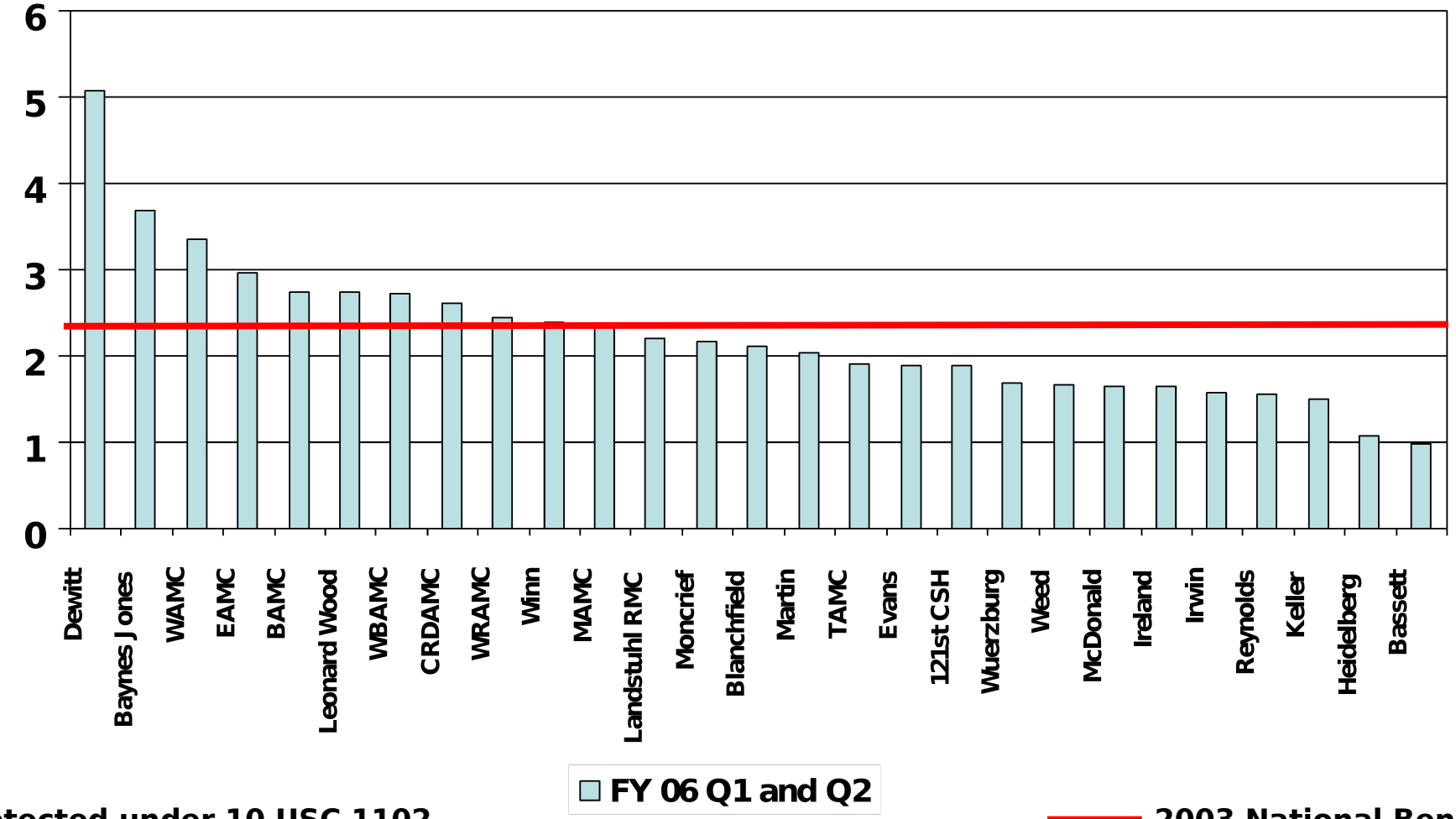
PSI 3: Decubitus Ulcer

(Risk Adjusted Rate per 100 Discharges)



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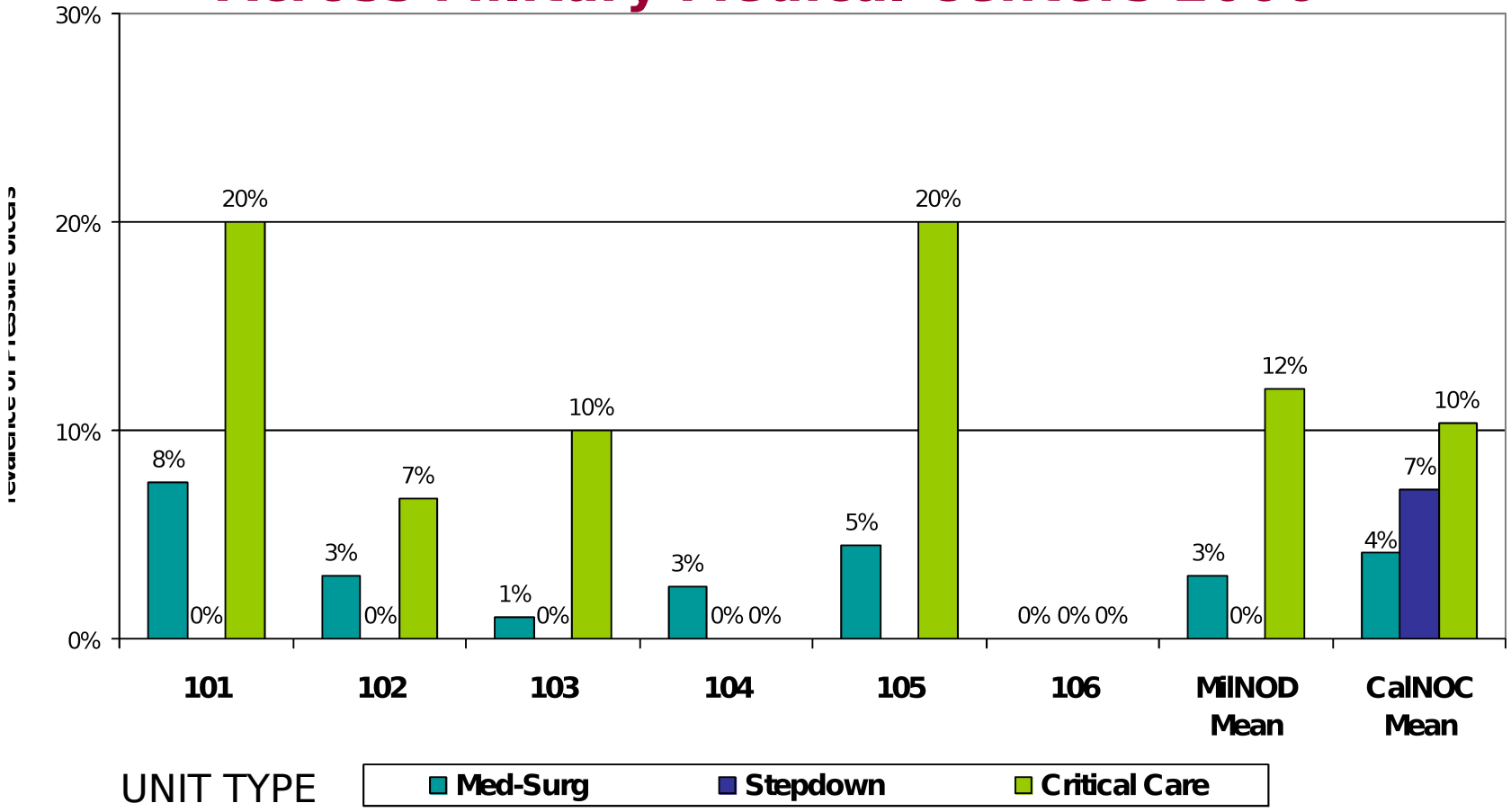
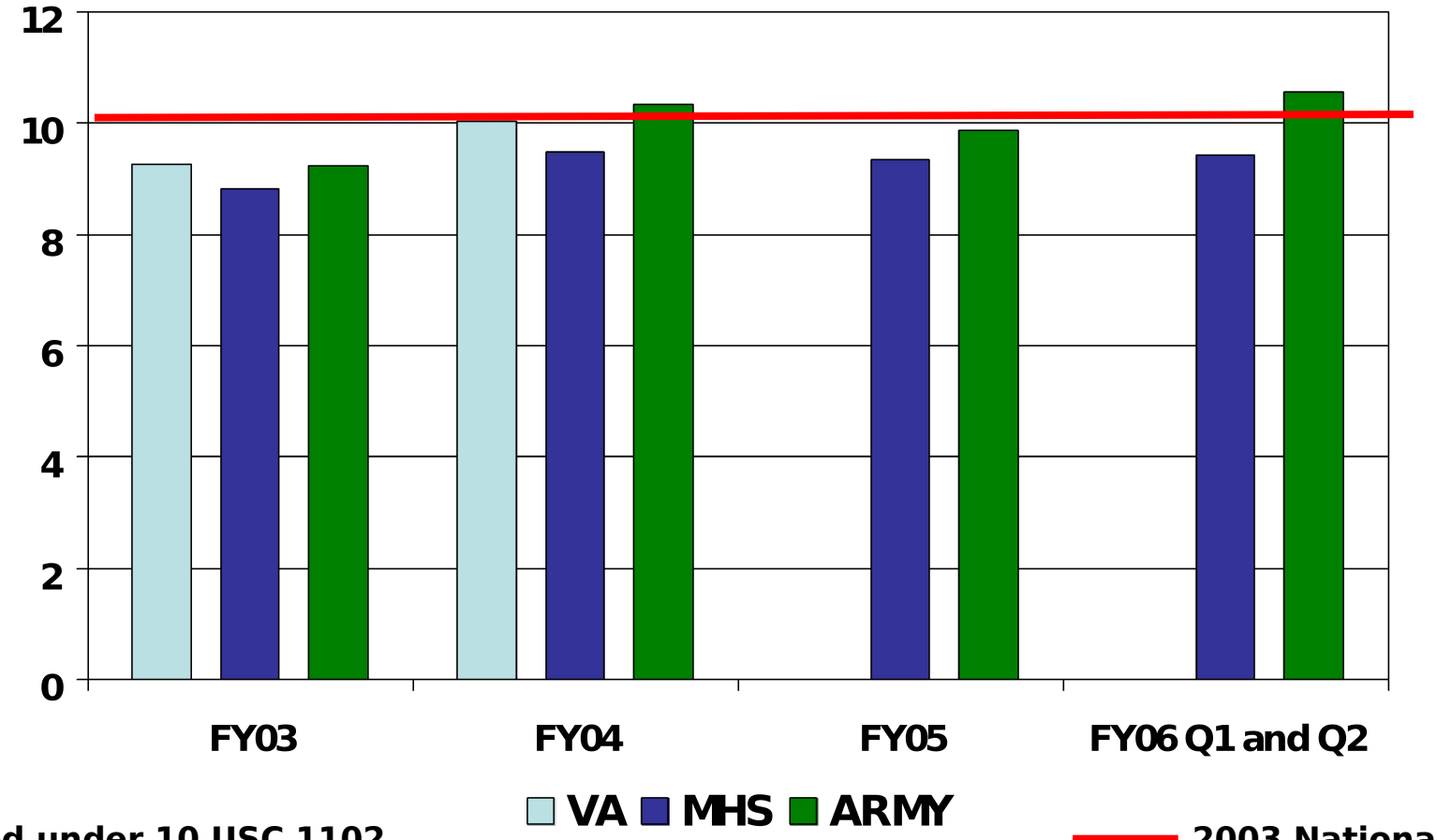
Cross-Sectional 1-Day Prevalence Survey of HOSPITAL ACQUIRED Pressure Ulcers Stage II or Above Across Military Medical Centers 2006



PSI 12: Post-Op PE or DVT (Risk Adjusted Rate per 1000 Surgical Discharges)



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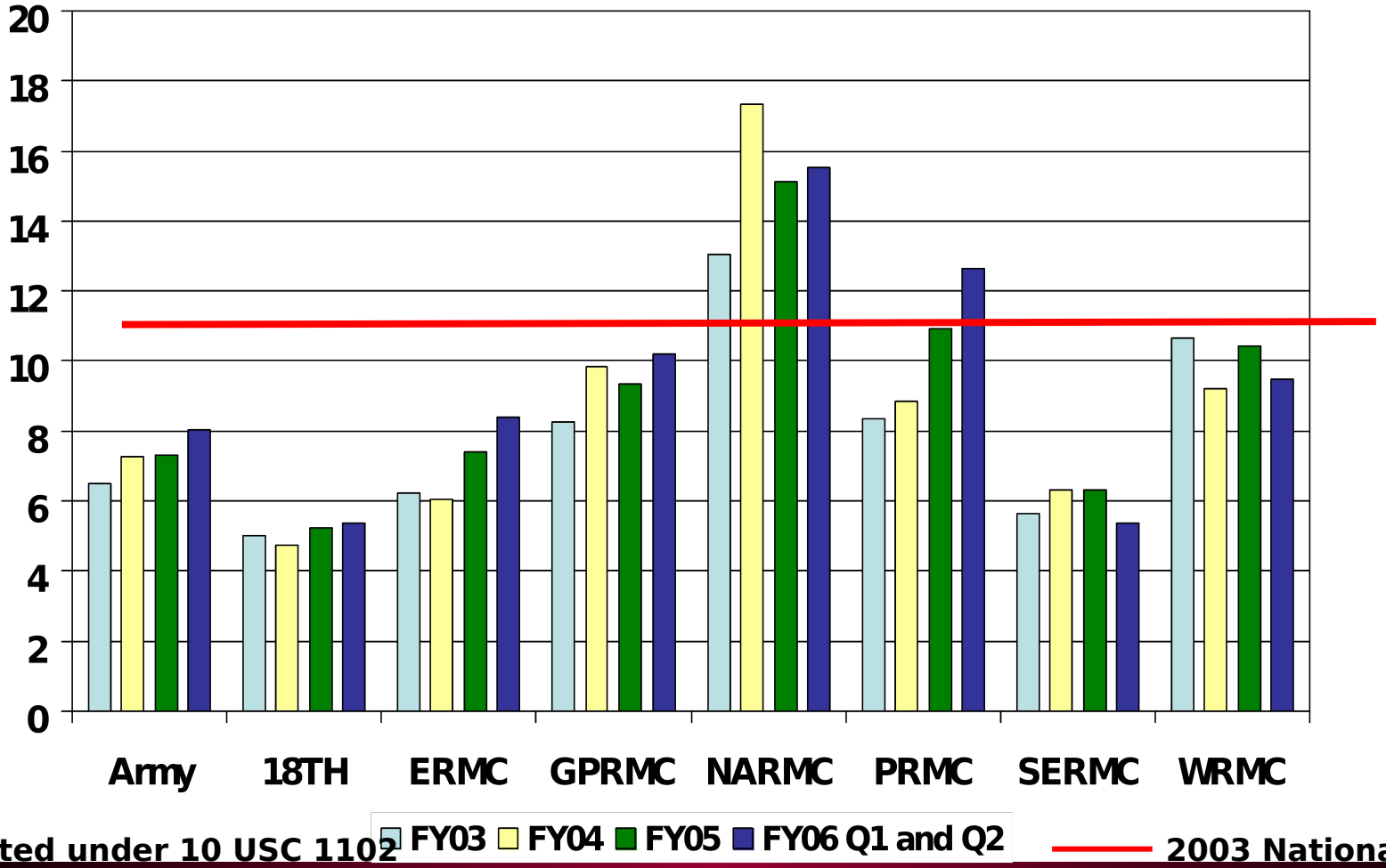

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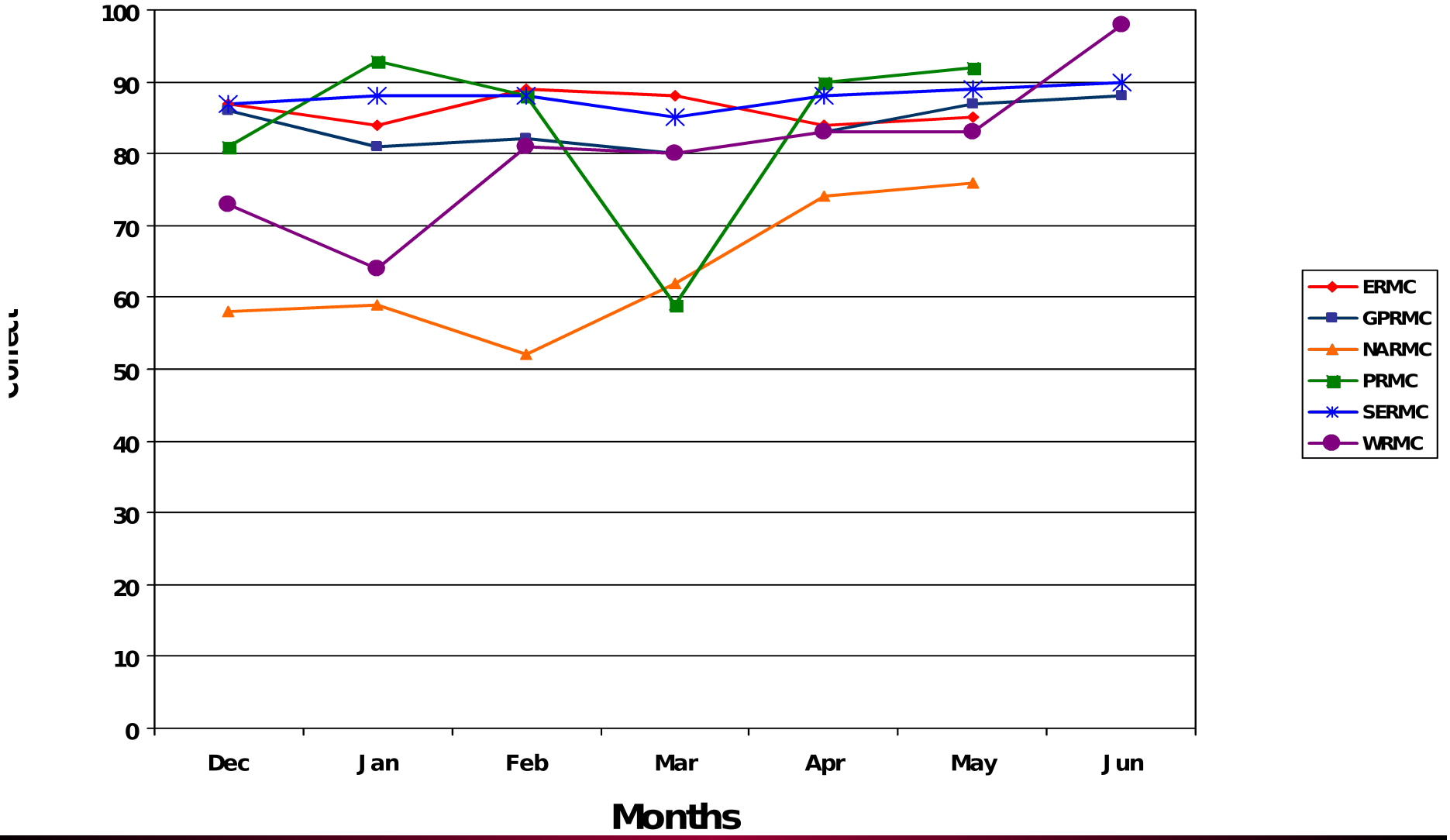
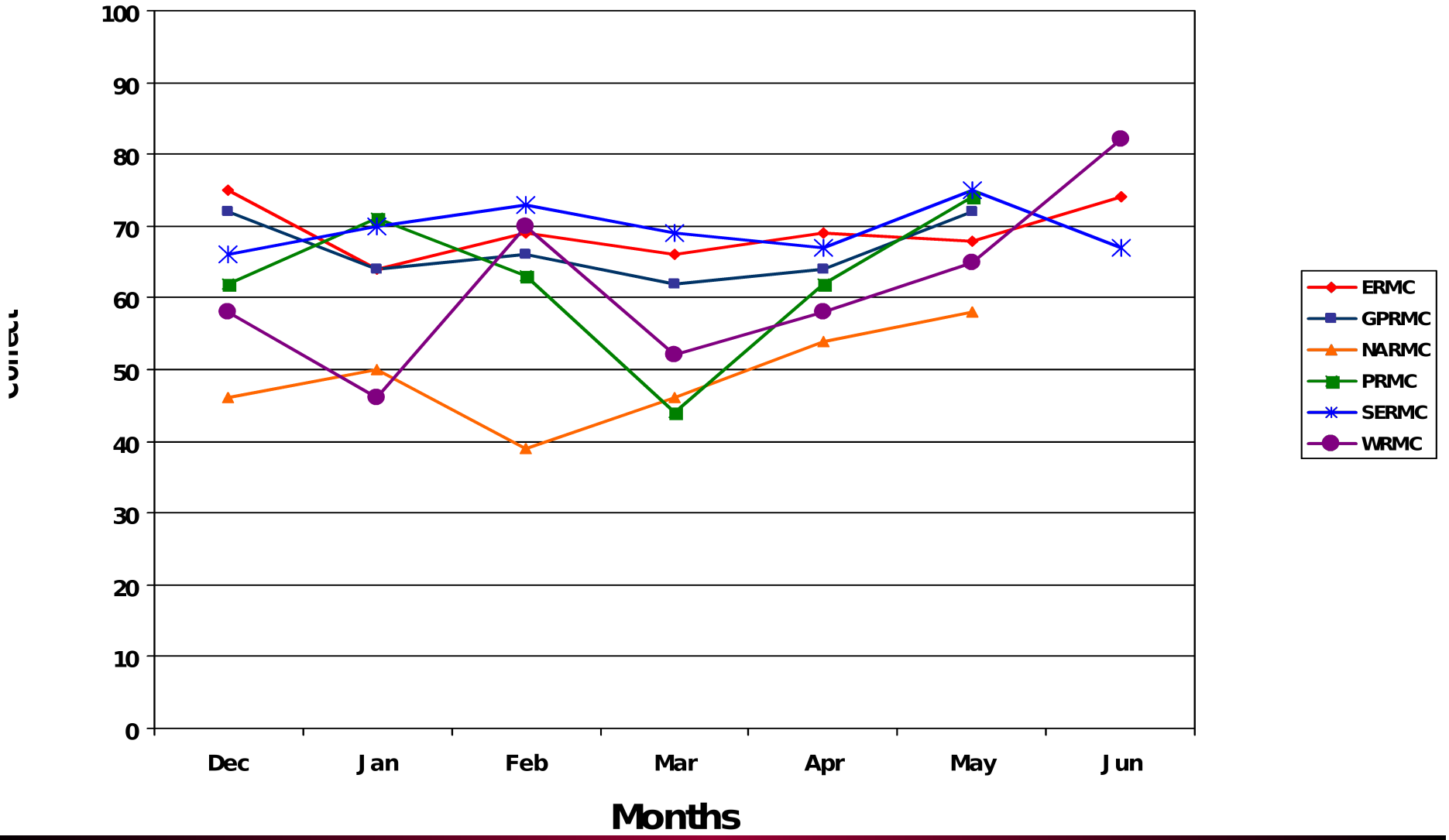
Patient Administration Systems and Biostatistics Activity

Trends in ICD9 Correctly Coded



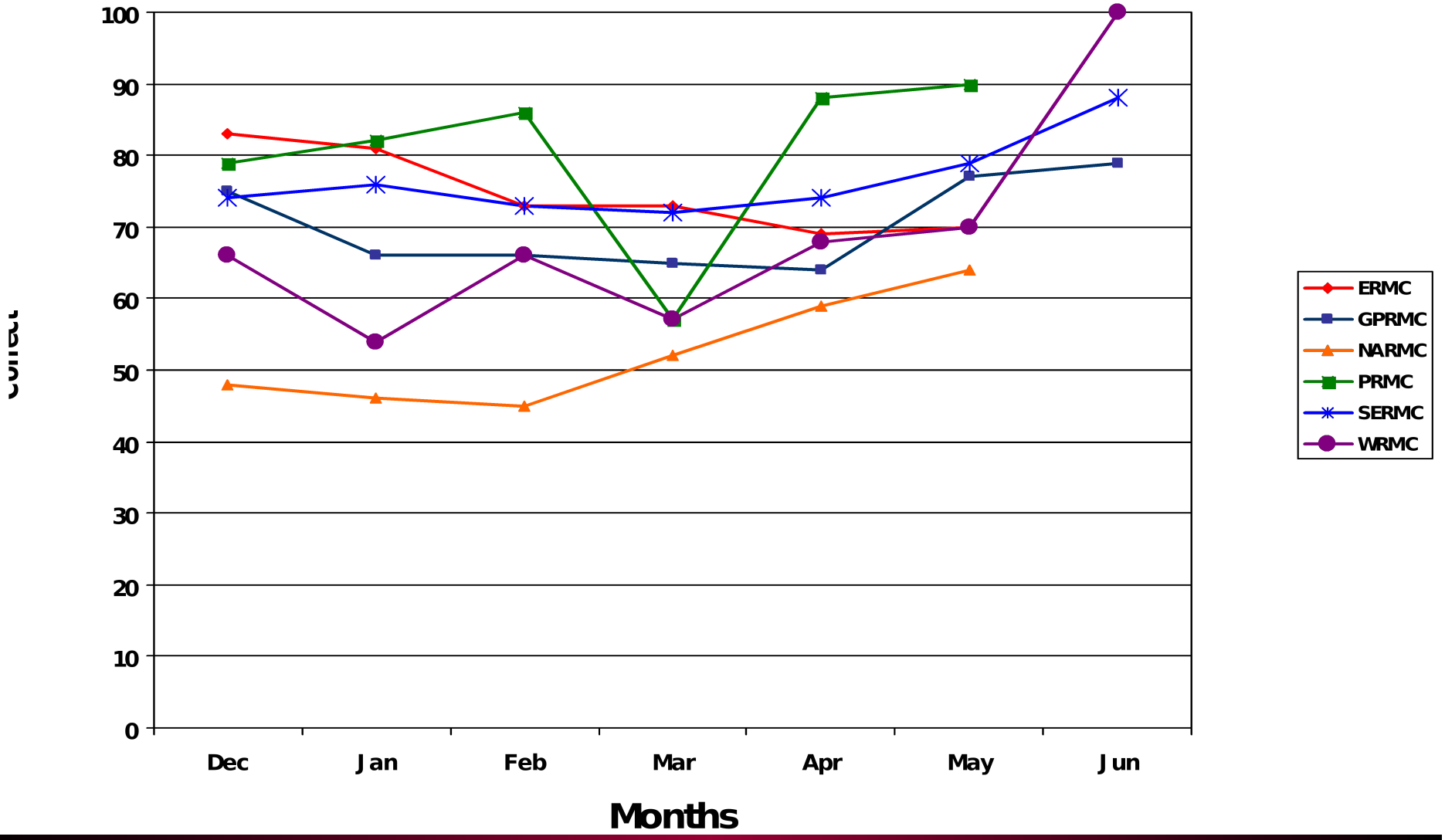
Patient Administration Systems and Biostatistics Activity

Trends of EM Correctly Coded

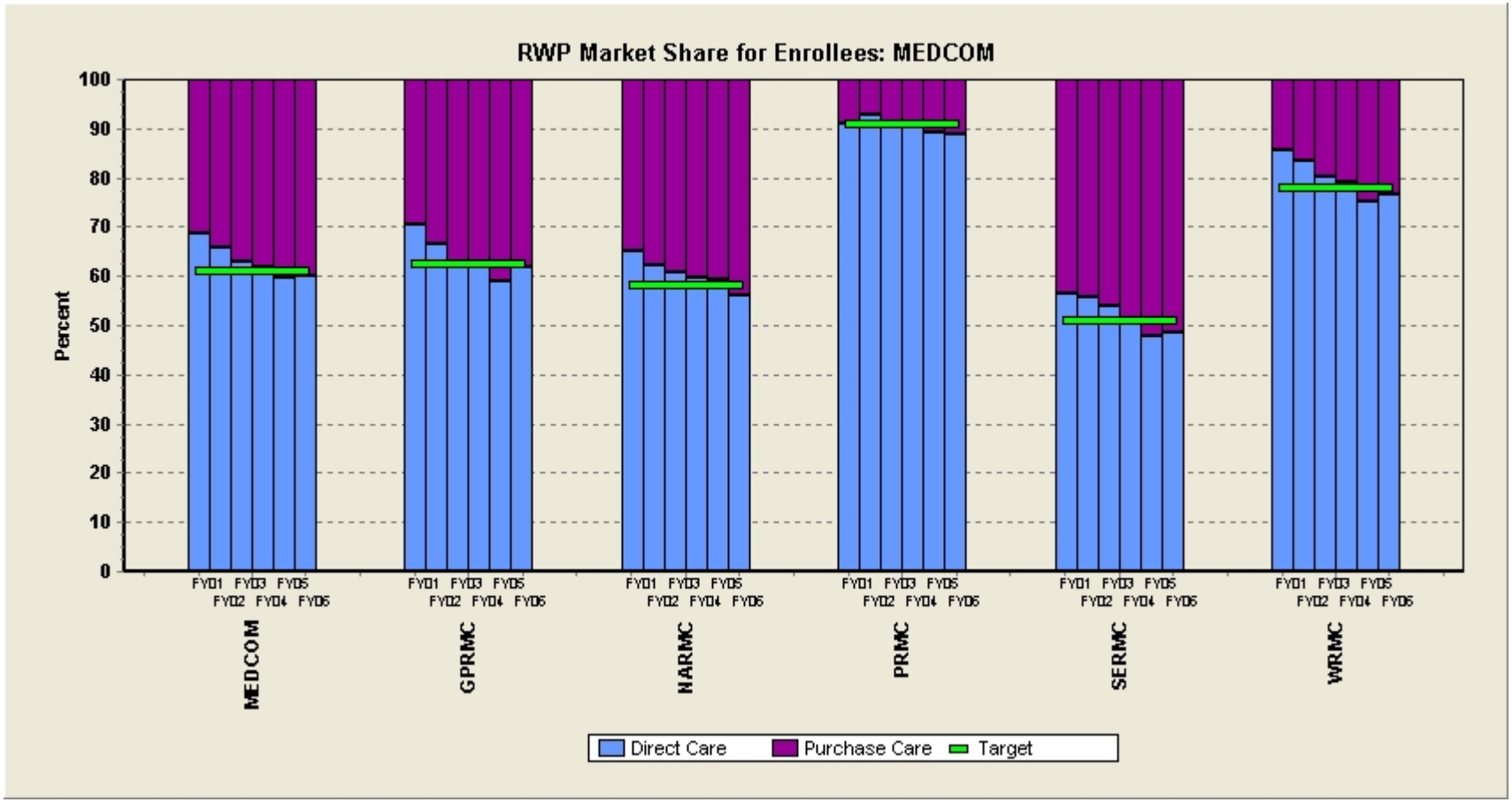


Patient Administration Systems and Biostatistics Activity

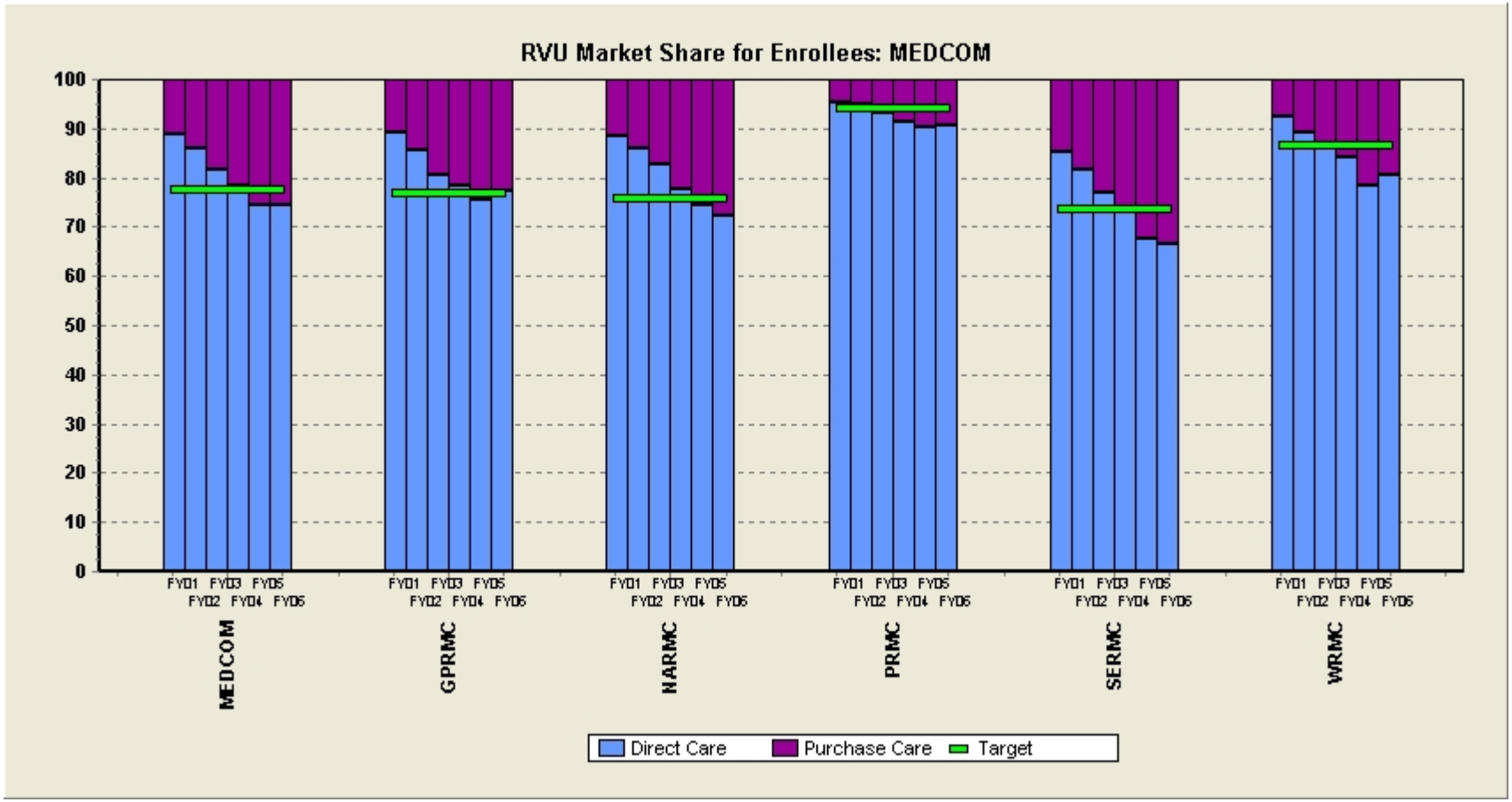
Trends of CPT Correctly Coded



Metric 76: RWP Market Share for Enrollees

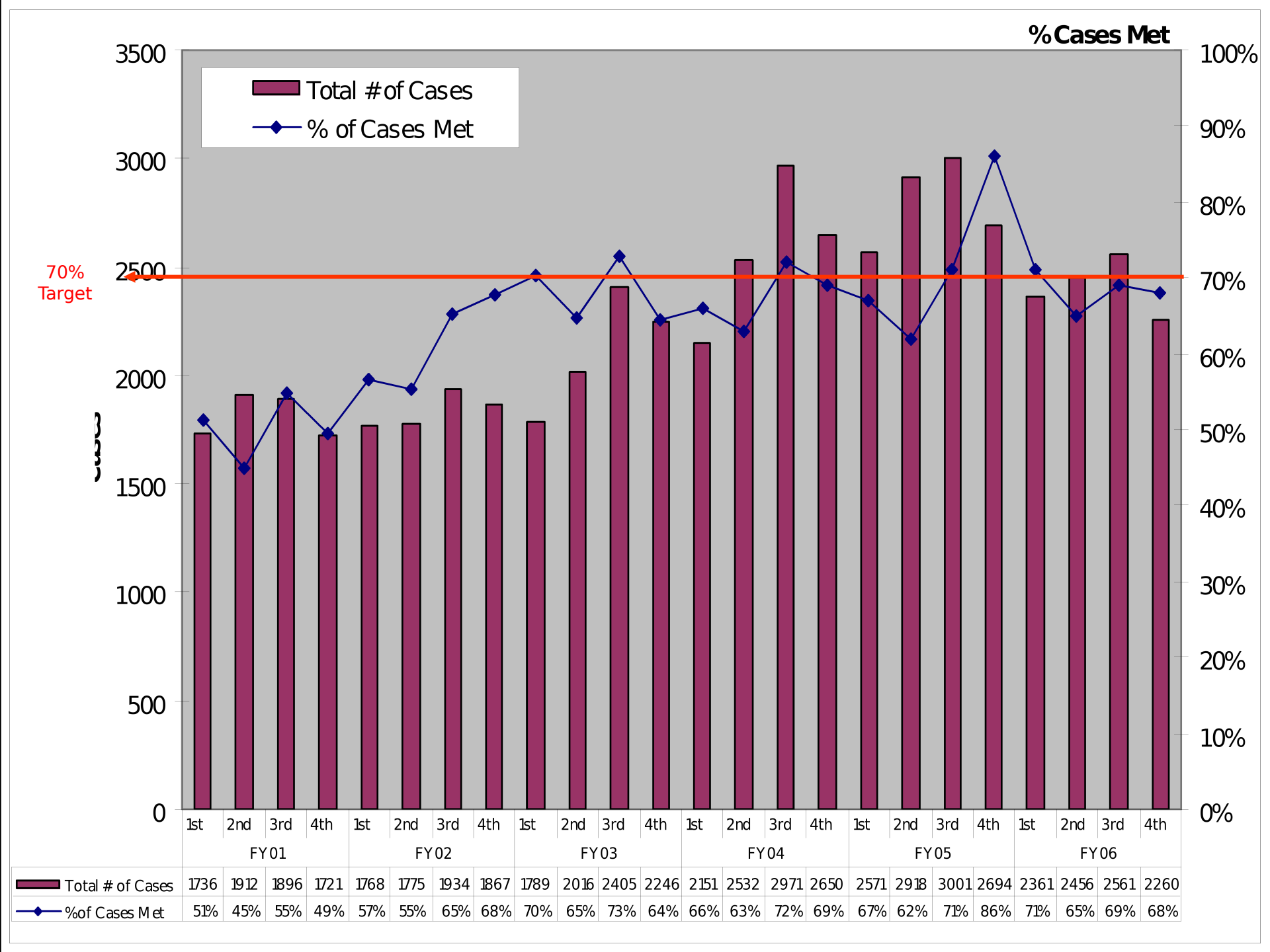


Metric 77: RVU Market Share for Enrollees

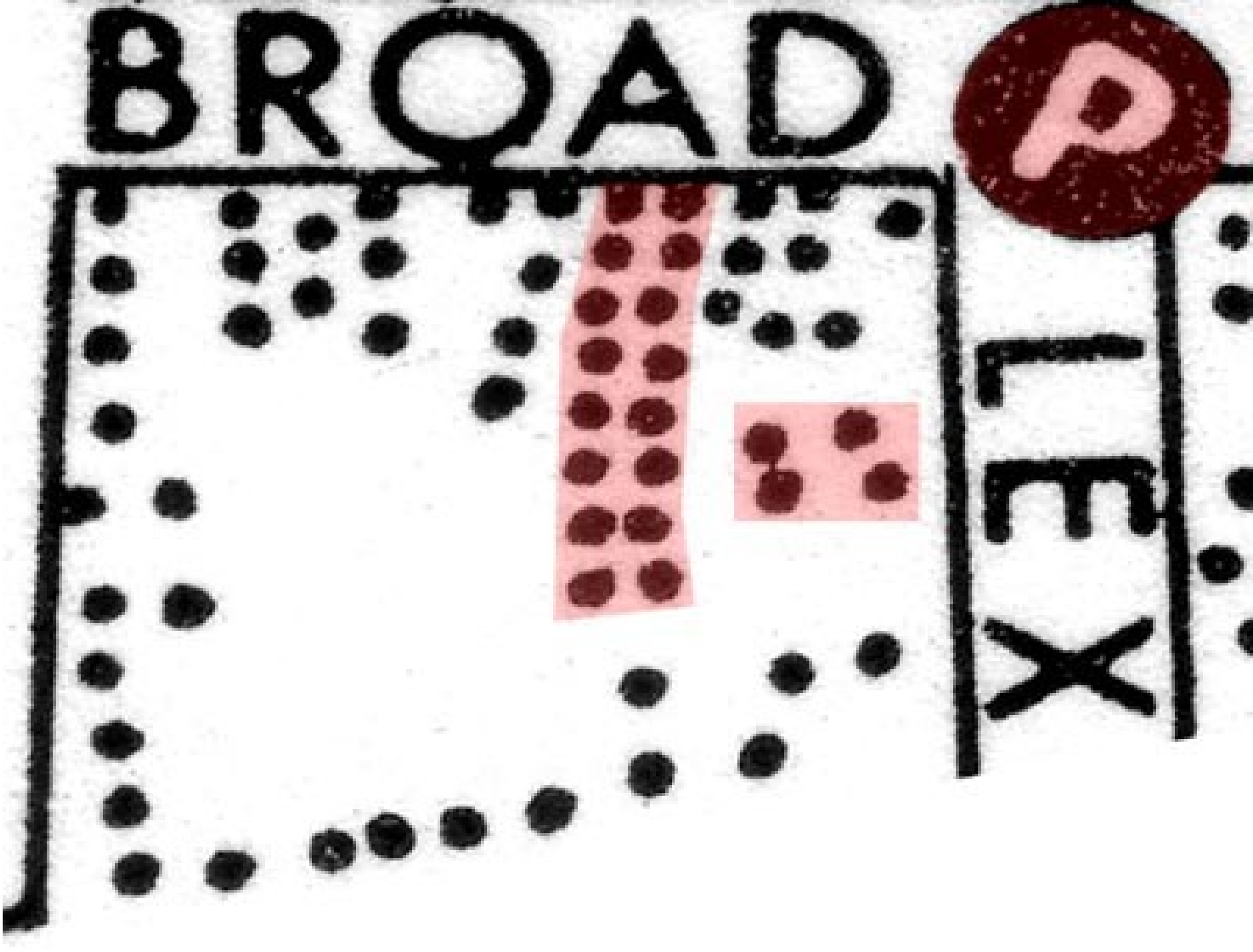


Patient Administration Systems and Biostatistics Activity

IP-13 Expedient, Compassionate Disposition of Medically Unfit Soldiers	**Measurement**	**IP-13a % of MEBs Processed in <90 days From Physician Initiation to Mailing** **IP-13b % of PEBs Completed & Final Disposition of Soldier by 130 Days.**			
	Measurement Intent	**IP-13a To monitor the MEB processing time at the MTF level.** **IP-13b Monitor case processing by physical disability agency.**			
Objective Statement	**PRIMARY ACCOUNTABILITY**	**SUPPORTING CAST**	**TARGET FY02**	**CURRENT STATUS**	**TARGETS FY03**
Develop and Implement a System that Quickly Identifies Unfit Soldiers and Makes dispositions (Return to Duty, Discharge), Efficiently, Effectively and Compassionately.	**COL Frank Berlingis PAD**	**COL John Kitsopoulos DCSPER** **COL Larry J. Clark PAD**	**IP-13a 80%; IP-13b 80%.**	55% MEBs Processed in <90 days From Physician Initiation, to Mailing 100% PEBs Completed & Final Disposition of Soldier by 130 Days	**IP-13a 90%; IP-13b 90%.**
INITIATIVES	**Implement Recommendations of the Process Action Team**				



	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th
	FY01				FY02				FY03				FY04				FY05				FY06			
Total # of Cases	1736	1912	1896	1721	1768	1775	1934	1867	1789	2016	2405	2246	2151	2532	2971	2650	2571	2918	3001	2694	2361	2456	2561	2260
%of Cases Met	51%	45%	55%	49%	57%	55%	65%	68%	70%	65%	73%	64%	66%	63%	72%	69%	67%	62%	71%	86%	71%	65%	69%	68%


BROAD
PLEX

https://cms.mods.army.mil/cms/secured/stoplights_frameset.aspx?measure=POPH - Microsoft Internet Explorer

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Address https://cms.mods.army.mil/cms/secured/stoplights_frameset.aspx?measure=POPH

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DHP | CMR | BSC | MED READINESS | PERSONNEL | RESERVES | MARKET ECON | POP HEALTH

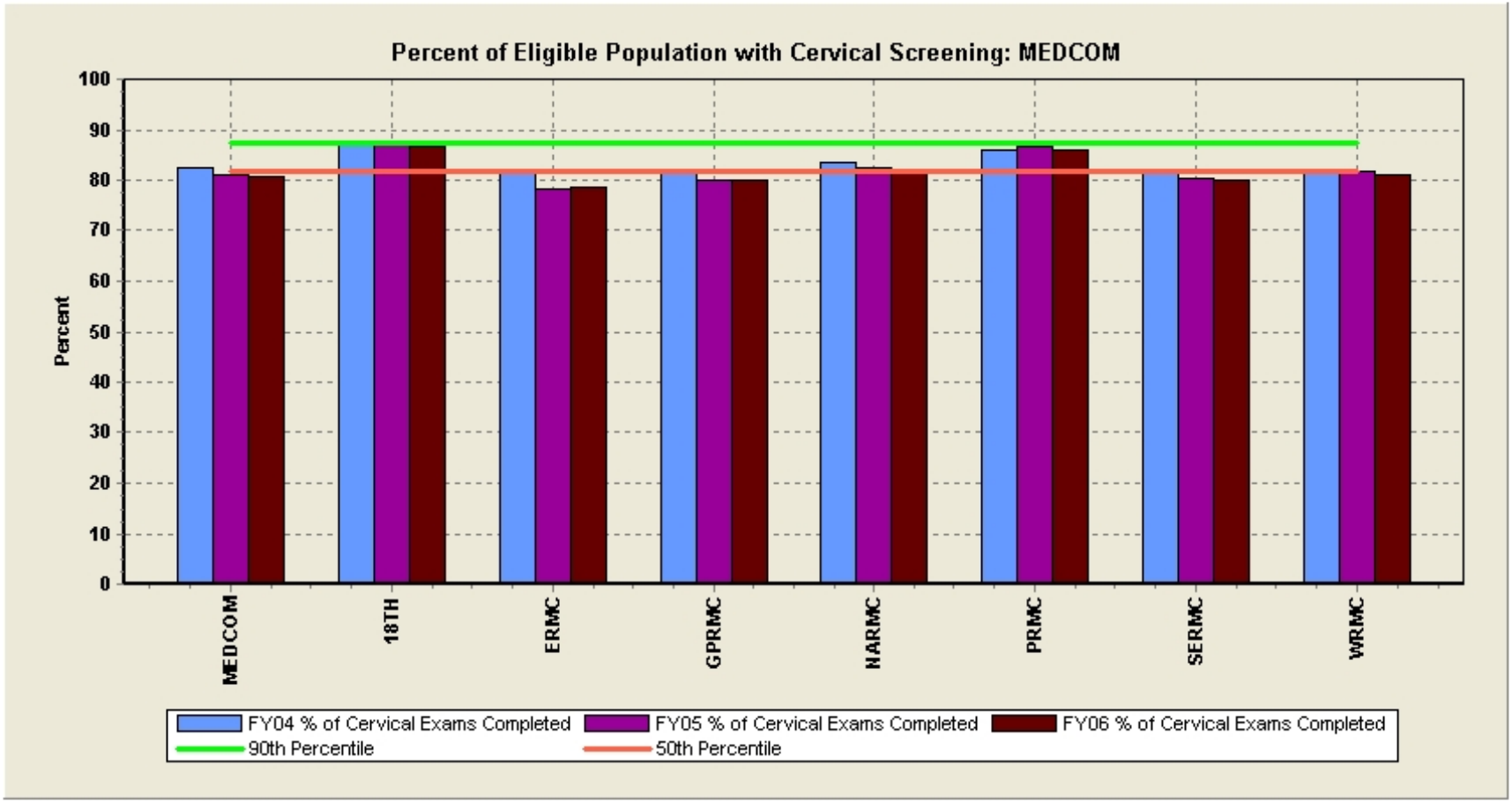
MEDC

	MEDC MEDCOM	18TH 18TH	ERMC ERMC	GPRM GPRMC	NARM NARMC	PRMC PRMC	SERM SERMC	WRMC WRMC
Evidence-based Healthcare								
Percent of Eligible Population with Mammogram	A	R	R	A	R	A	A	A
Percent of Eligible Population with Asthma on LTC Medications	G	G	G	G	G	G	G	G
Percent of Eligible Population with Diabetes with A1C Testing	R	R	R	R	R	A	R	R
Percent of Eligible Population with Diabetes with A1C < 9	A	R	R	A	A	A	R	A
Percent of Eligible Population with Diabetes with LDL < 100	G	A	R	G	G	G	G	G
Percent of Eligible Population with Cervical Screening	R	A	R	R	R	A	R	R
Percent of Eligible Population with Colo-Rectal Exam	A	R	R	A	A	A	A	A

RMCs by Fiscal Year

AMEDDCMS

Data Last Refreshed: 10/2/2006 3:14:00 PM
Date Chart Created: 10/10/2006 12:01:23 AM



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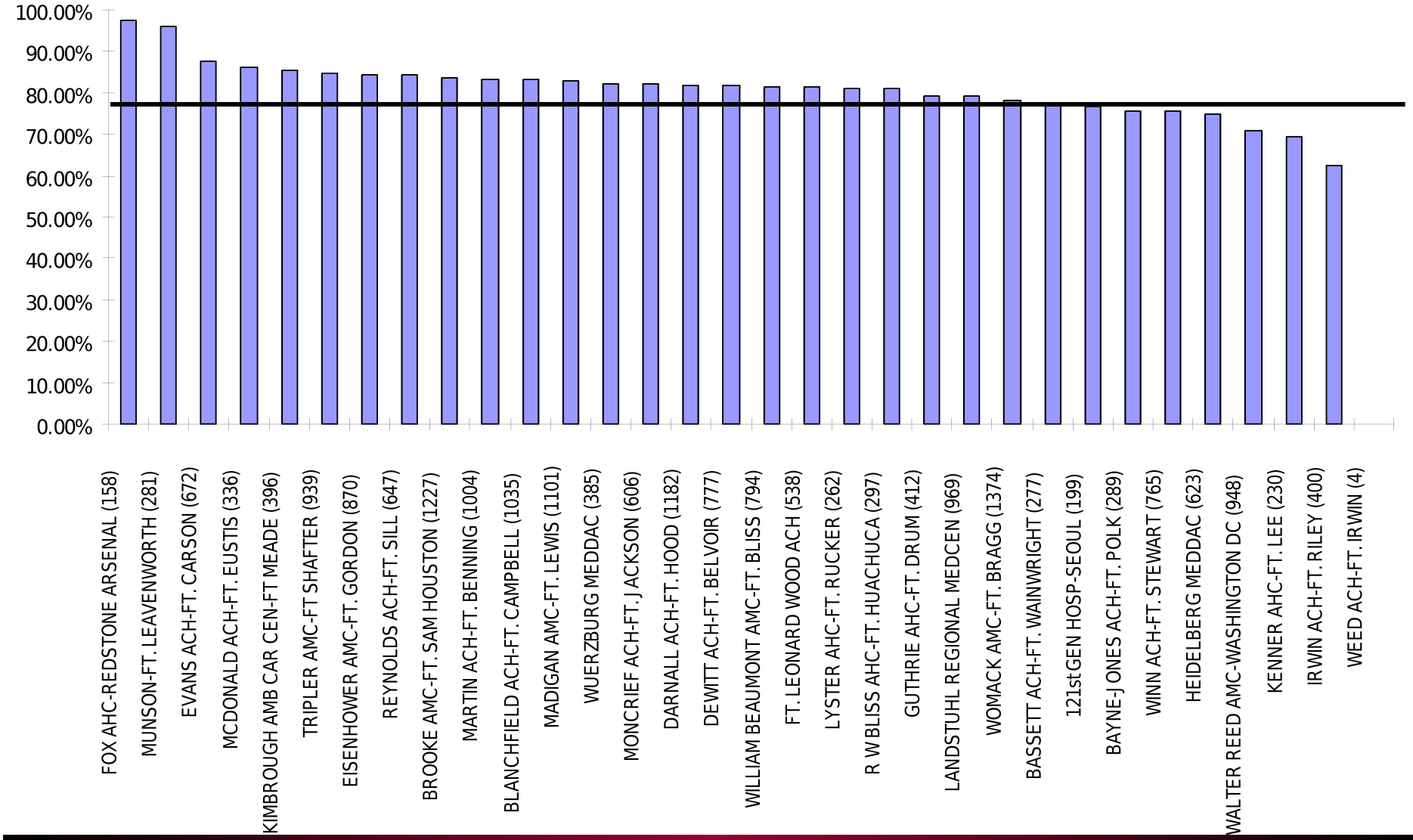
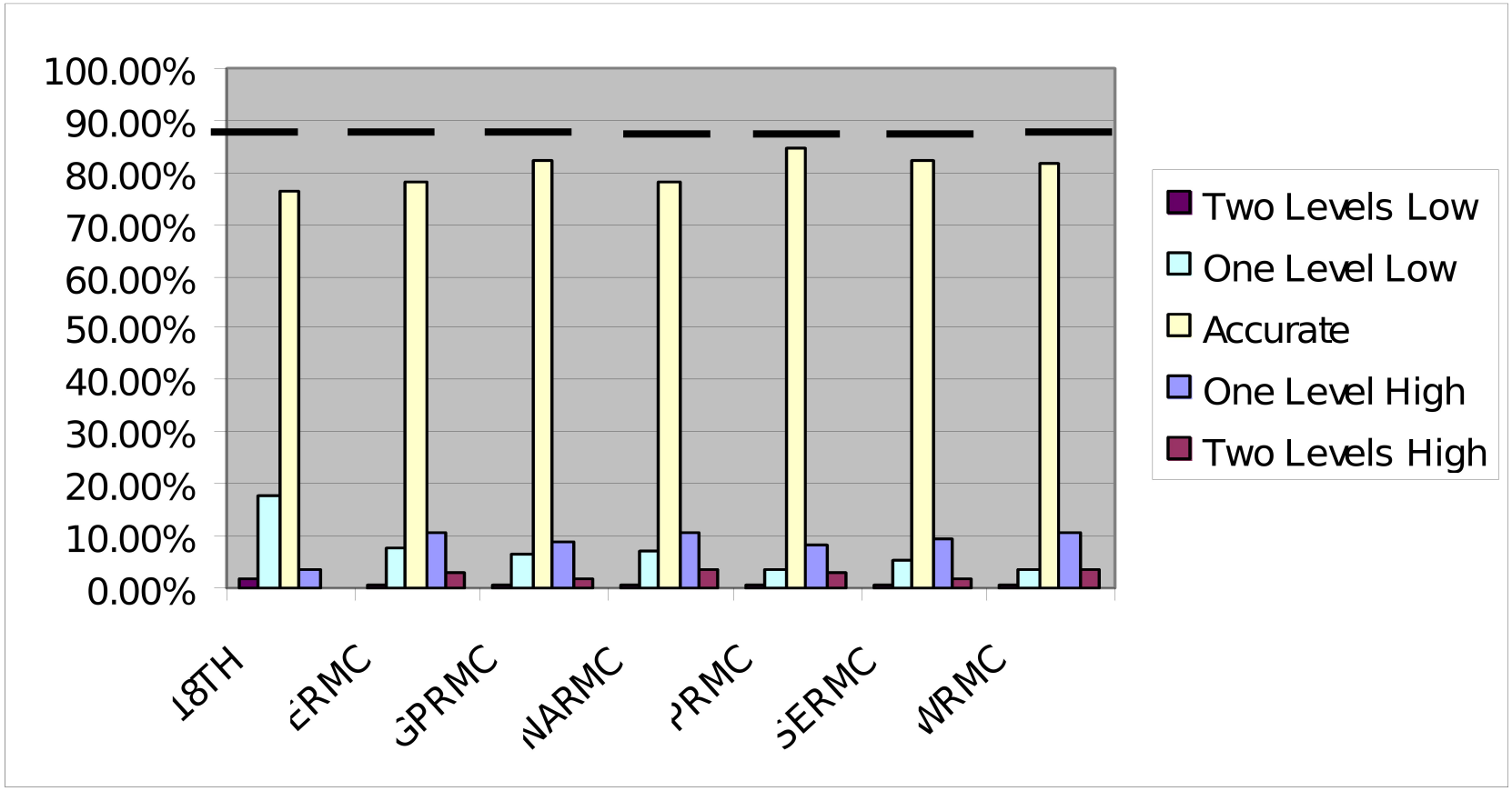
E&M ACCURACY

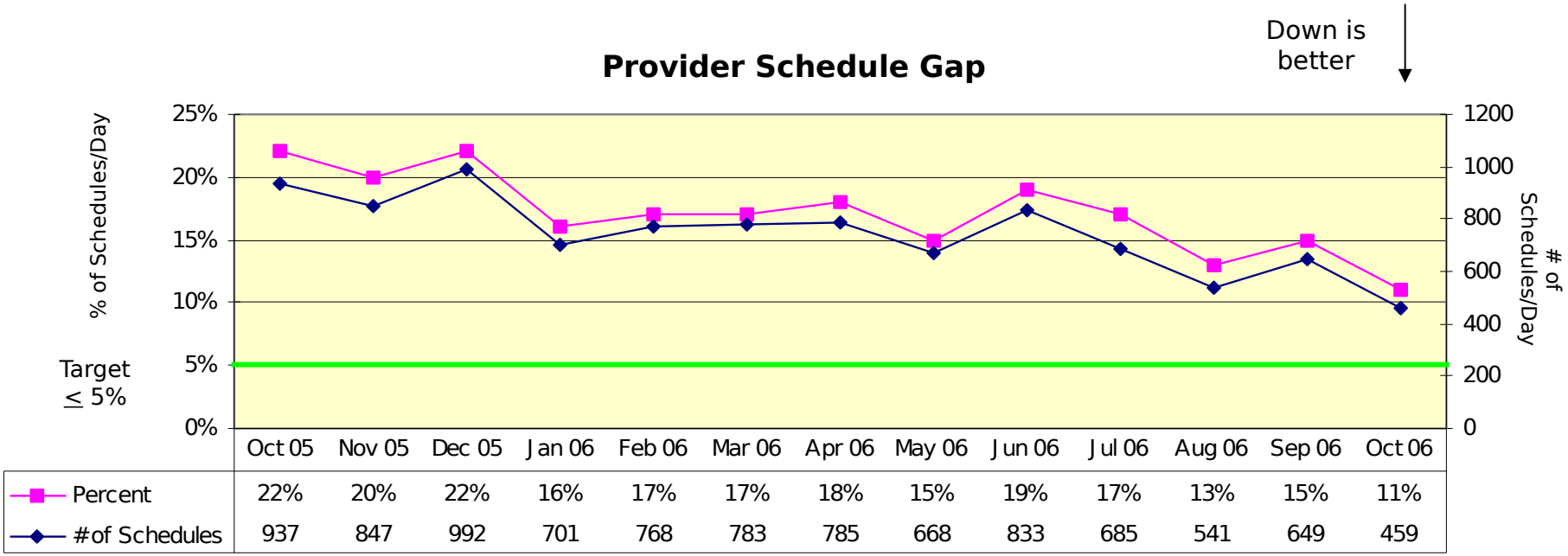

100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
FOX AHC-REDSTONE ARSENAL (158)
MUNSON-FT. LEAVENWORTH (281)
EVANS ACH-FT. CARSON (672)
MCDONALD ACH-FT. EUSTIS (336)
KIMBROUGH AMB CAR CEN-FT MEADE (396)
TRIPLER AMC-FT SHAFTER (939)
EISENHOWER AMC-FT. GORDON (870)
REYNOLDS ACH-FT. SILL (647)
BROOKE AMC-FT. SAM HOUSTON (1227)
MARTIN ACH-FT. BENNING (1004)
BLANCHFIELD ACH-FT. CAMPBELL (1035)
MADIGAN AMC-FT. LEWIS (1101)
WUERZBURG MEDDAC (385)
MONCRIEF ACH-FT. J ACKSON (606)
DARNALL ACH-FT. HOOD (1182)
DEWITT ACH-FT. BELVOIR (777)
WILLIAM BEAUMONT AMC-FT. BLISS (794)
FT. LEONARD WOOD ACH (538)
LYSTER AHC-FT. RUCKER (262)
R W BLISS AHC-FT. HUACHUCA (297)
GUTHRIE AHC-FT. DRUM (412)
LANDSTUHL REGIONAL MEDCEN (969)
WOMACK AMC-FT. BRAGG (1374)
BASSETT ACH-FT. WAINWRIGHT (277)
121stGEN HOSP-SEOUL (199)
BAYNE-J ONES ACH-FT. POLK (289)
WINN ACH-FT. STEWART (765)
HEIDELBERG MEDDAC (623)
WALTER REED AMC-WASHINGTON DC (948)
KENNER AHC-FT. LEE (230)
IRWIN ACH-FT. RILEY (400)
WEED ACH-FT. IRWIN (4)

E&M Variance by Region



Provider Schedule Gap Update

MEDCOM 30-Day Provider Schedule Gap Trend Analysis Oct 05 – Oct 06



	Oct 05	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06
Percent	22%	20%	22%	16%	17%	17%	18%	15%	19%	17%	13%	15%	11%
#of Schedules	937	847	992	701	768	783	785	668	833	685	541	649	459

Source: TRICARE Operations Center

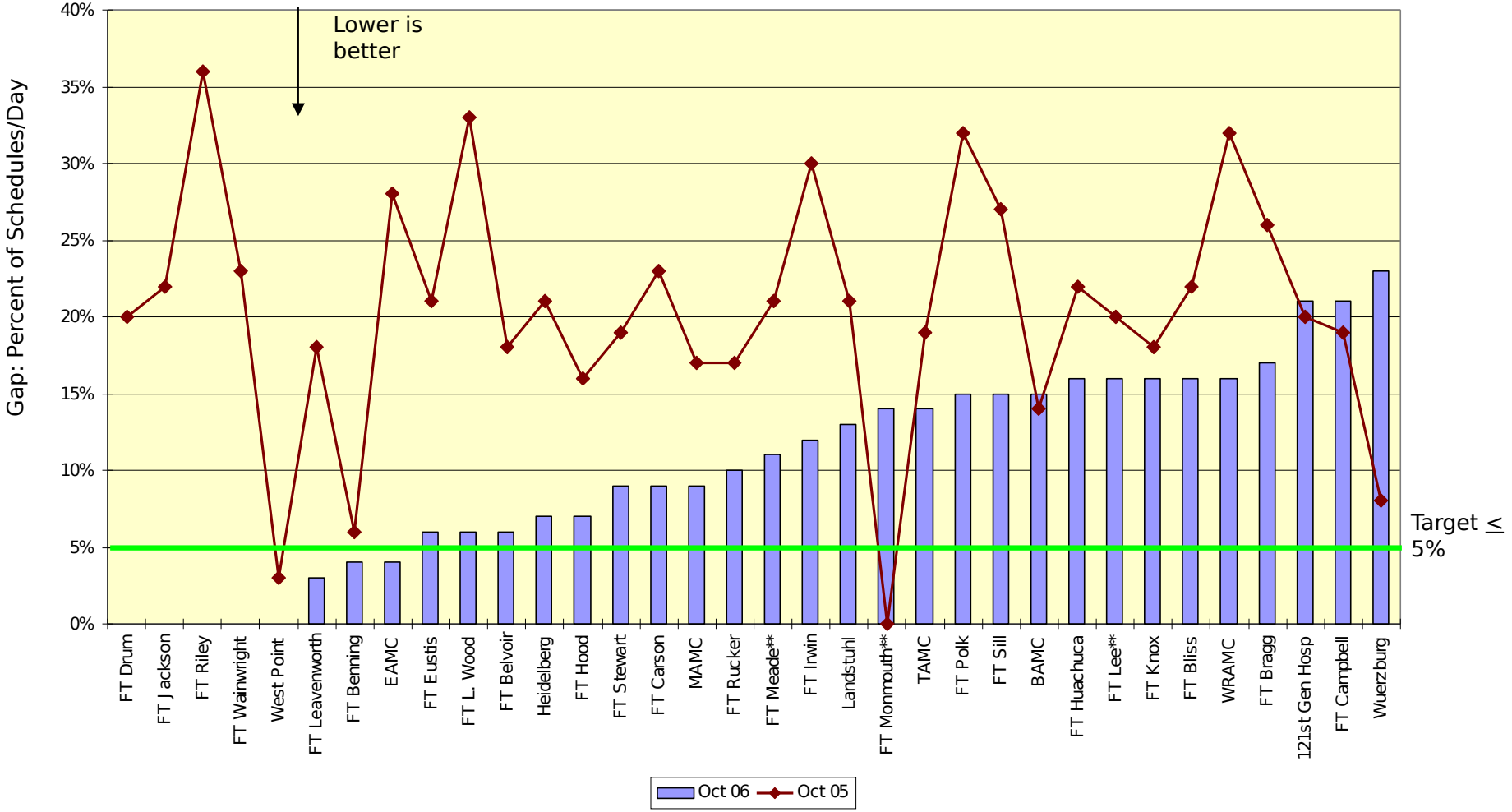
Data pulled 13 Oct 06

Provider Schedule Gap Update

Provider Schedule Gap By Percent

MTFs

Oct 05 vs. Oct 06



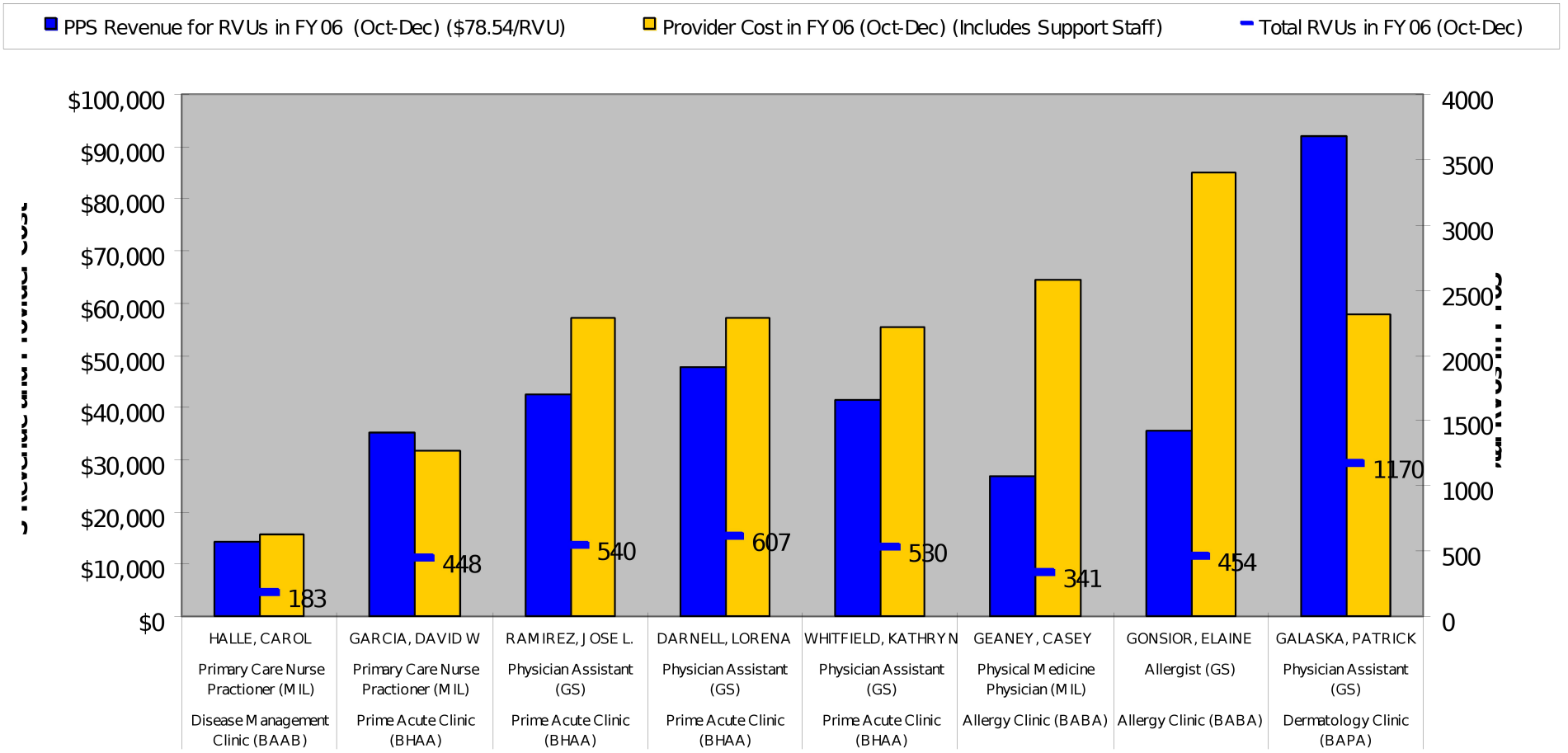
Excludes weekends & fed/trng holidays

Source: TRICARE Operations Center

**FT Meade, FT Lee and FT Monmouth data as of Jun 06

Data pulled 10 Oct 05 & 13 Oct 06

PPS Revenue v. Provider Cost
RVU only
Dis.Mgt, Prime Acute, Allergy, Dermatology



Provider Scorecard Example

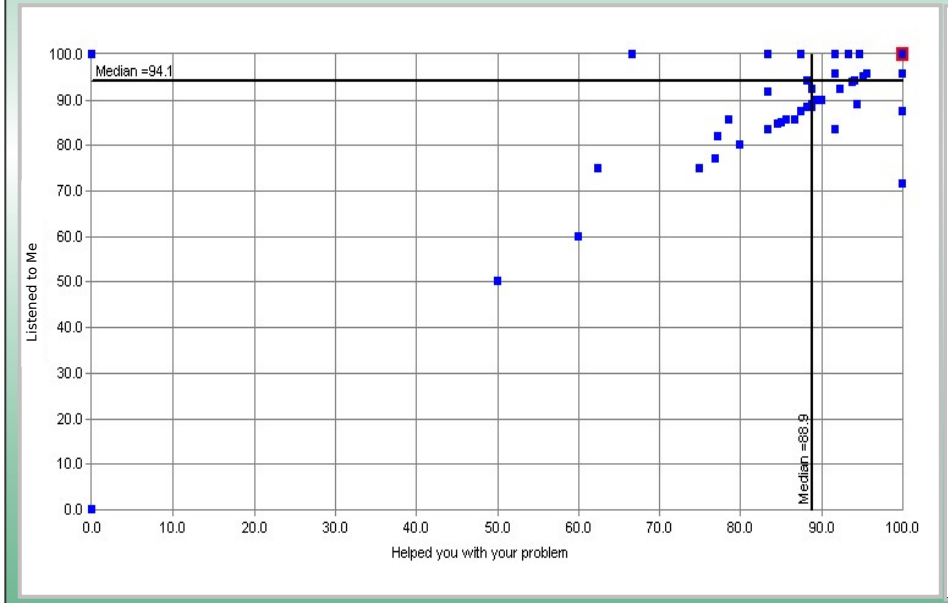
Scorecard
Provider Name: NOTIONAL DATA
Ft. Benning - Martin Army Community Hospital (Ft Benning)
Specialty -- Family Practice

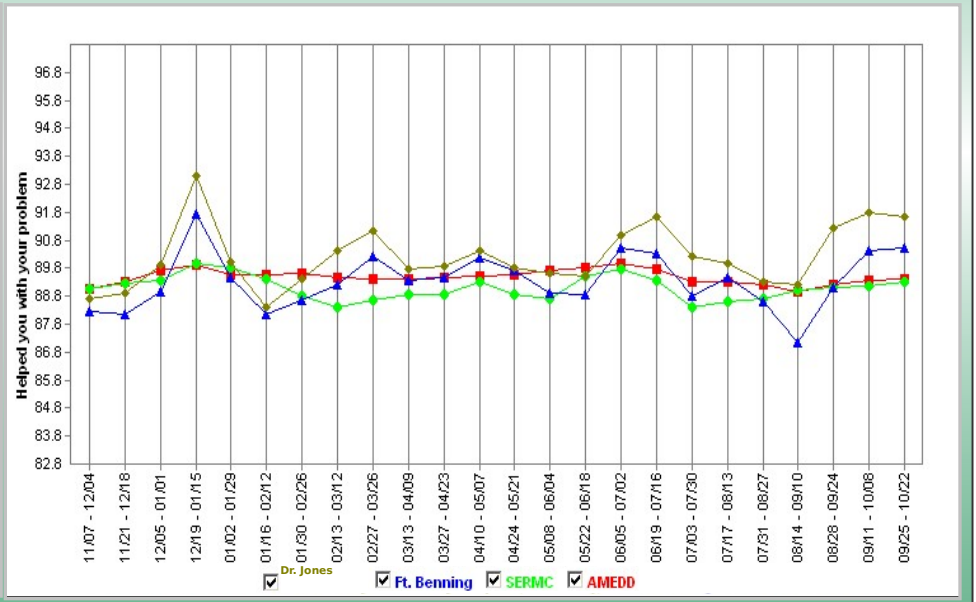
Provider Specialty	52 Weeks	Period of review	Past 4 Weeks	Past 12 Weeks	Past 52 Weeks
		2006	9/25/2006 - 10/22/2006	7/31/2006 - 10/22/2006	10/24/2005 - 10/22/2006

SATISFACTION

	Your Scores			Comparative MEPR Scores*		
	Past 4 Weeks	Past 12 Weeks	Past 52 Weeks	Hospital/Clinic Past 12 Weeks	Post Past 12 Weeks	RMC Past 12 Weeks
Number of Returns	9	26	115	1,965	2,751	
Helped Patient with Problem	100.0%	100.0%	100.0%	25,998	91.0%	90.7%
Listened to Patient	100.0%	100.0%	100.0%	91.0%	91.0%	90.7%

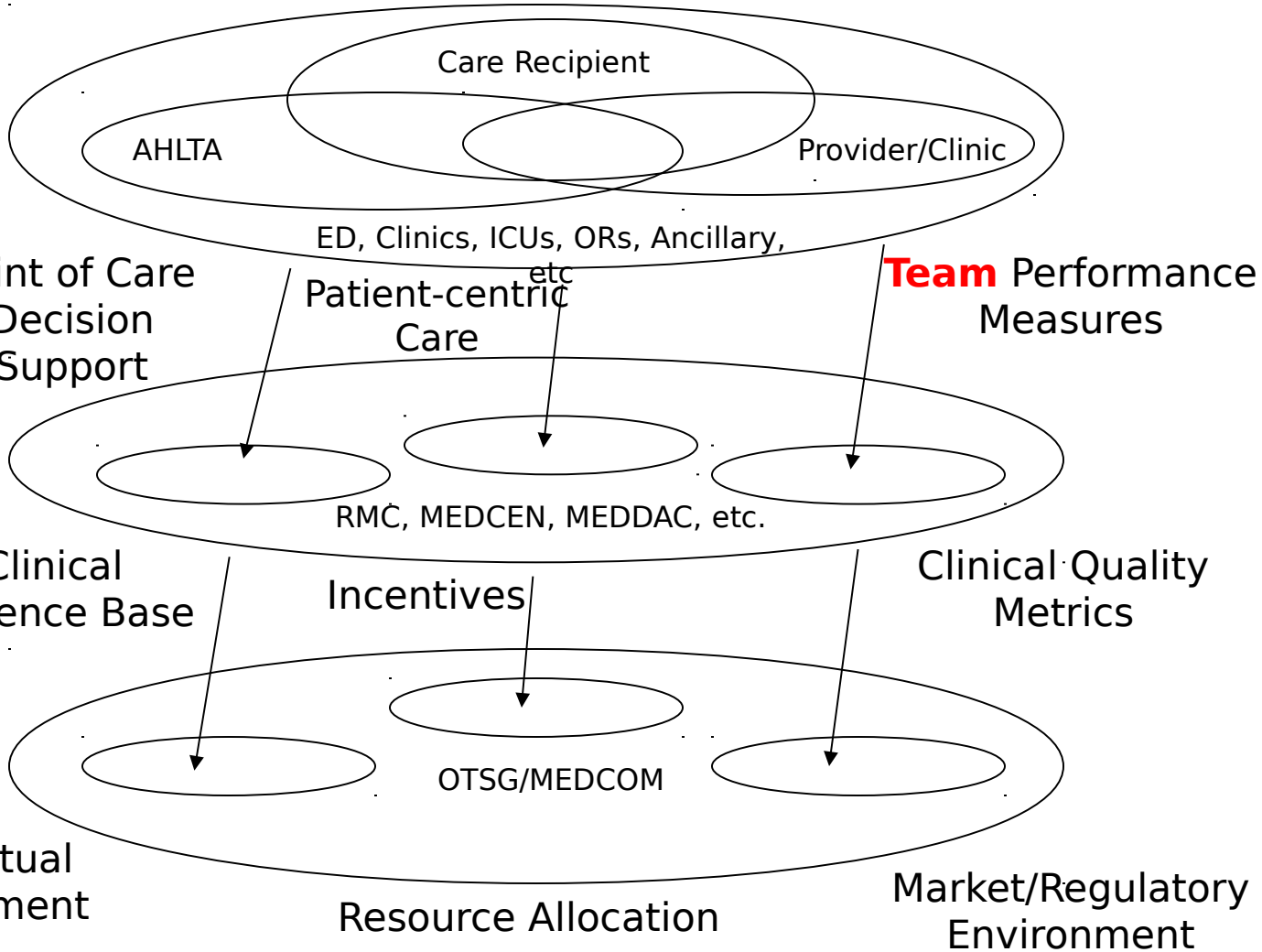
Data Source: APLSS





Developing Metrics and Assigning Accountability

Health Systems Levels: Micro-, Meso-, and Macrosystems

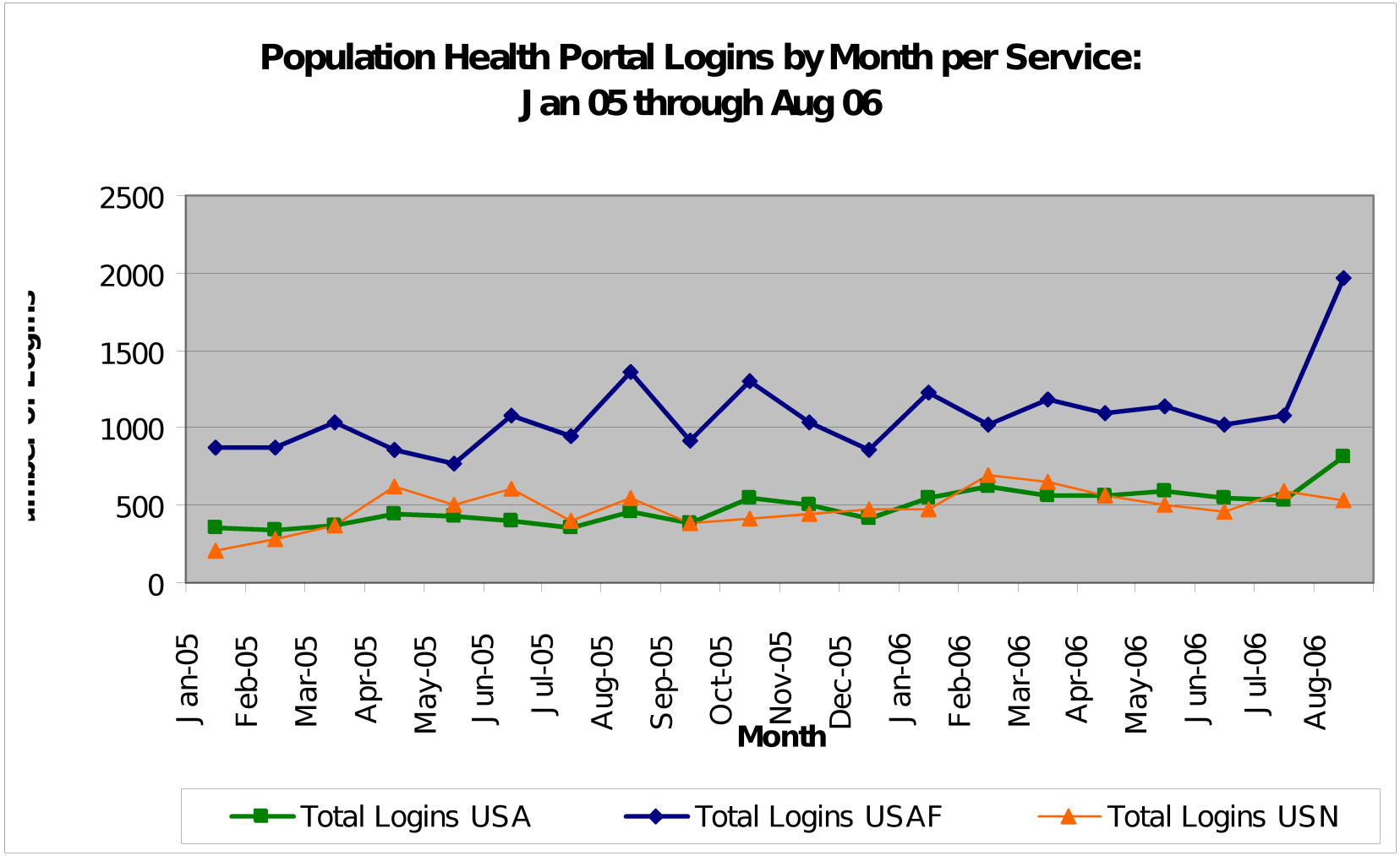


Pneumovax Incentive Plan

- **Implementation year**
  - Cost to administer vaccine:
    - Baseline rate for action at the MTF determined from previous year data.
    - MTFs reimbursed for all activity above baseline using a cost plus module for the first year based upon their annualized rate during the implementation year at $10 per immunization above the baseline rate.
    - The delta cost provided for this part of the incentive will be added to the MTFs next year budget
- **Implementation Year Reward Metric (population based)**
  - Targets now established by policy and a snapshot will be take on the following dates: 1 Jan 07, I Jun 07, 1 Jan 08
  - Reward Schema (same patient could contribute to reward 3 times)
    - 1 Jan 07- $5 for all benes age $\geq$ 65 who have had the vaccine if MTF $\geq$ 45%
    - 1 Jun 07 - $5 for all benes age $\geq$ 65 who have had the vaccine if MTF $\geq$ 65%
    - 1 Jan 08 - $5 for all benes age $\geq$ 65 who have had the vaccine if MTF $\geq$ 95%
- **PBAM - Maintenance Year Reward Metric (population based)**
  - Target is **$\geq$ 95%** in maintenance phase and snapshot will be taken on the following dates: 1 Jun 08 and 1 Jan 09
  - Reward schema (same patient could contribute to reward 2 times)
    - MTF receives $5 for all patients 65 and over who have had the vaccine if MTF $\geq$ 95%

Evidence Based Medicine Performance Payments

Enrollment Parent MTF	% Eligible Women with Mammo	% Eligible Women with Pap	% Diabetics with A1c Screening	% Diabetics A1c<=9.0	% Diabetics with LDL<100mg/dl	% Asthmatics with Appropriate Meds	Total
FT LEAVENWORTH	$3,345	$14,905	$1,580	$2,830	$2,170	$2,580	$27,410
TRIPLER AMC	$4,825	$35,975	$4,265	$3,770	$5,660	$3,680	$58,175
BROOKE AMC	$18,625	$40,805	$12,830	$11,415	$16,660	$6,630	$106,965
CAMP ZAMA	$0	$1,575	$220	$200	$130	$160	$2,285
FT MEADE	$0	$36,735	$5,345	$4,450	$6,280	$5,350	$58,160
MADIGAN AMC	$0	$0	$14,990	$13,310	$21,990	$5,270	$55,560
FT EUSTIS	$0	$0	$4,080	$7,410	$4,260	$5,480	$21,230
FT CARSON	$0	$15,925	$5,040	$9,140	$6,200	$2,920	$39,225
FT BELVOIR	$0	$0	$12,805	$11,075	$16,990	$9,240	$50,110
FT SILL	$4,595	$0	$4,375	$3,905	$5,350	$4,010	$22,235
FT RUCKER	$3,635	$0	$2,205	$1,795	$1,075	$1,730	$10,440
WALTER REED AMC	$6,255	$18,525	$0	$0	$6,050	$2,220	$33,050
EISENHOWER AMC	$14,045	$0	$11,480	$9,495	$13,230	$4,040	$52,290
FT L. WOOD	$0	$0	$2,775	$2,455	$3,140	$2,570	$10,940
REDSTONE	$0	$0	$2,310	$1,970	$2,610	$950	$7,840
121ST KOREA	$0	$12,540	$0	$325	$420	$1,100	$14,385
FT BENNING	$8,120	$42,225	$0	$0	$8,750	$3,440	$62,535
FT IRWIN	$0	$6,870	$0	$450	$540	$700	$8,560
FT JACKSON	$7,040	$0	$0	$0	$4,270	$1,780	$13,090
FT HOOD	$6,725	$0	$0	$0	$6,410	$8,250	$21,385
WOMACK AMC	$0	$0	$0	$0	$4,670	$7,270	$11,940
FT LEE	$0	$0	$0	$0	$965	$1,980	$2,945
WEST POINT	$0	$0	$0	$0	$1,080	$940	$2,020
FT CAMPBELL	$6,130	$0	$4,880	$4,020	$5,000	$7,280	$27,310
FT HUACHUCA	$0	$0	$0	$0	$2,320	$1,500	$3,820
FT WAINWRIGHT	$0	$8,550	$0	$760	$980	$1,180	$11,470
FT RILEY	$0	$0	$0	$0	$2,000	$2,990	$4,990
WM BEAUMONT AMC	$0	$0	$0	$0	$6,210	$5,170	$11,380
FT STEWART	$0	$0	$0	$0	$5,300	$4,180	$9,480
FT POLK	$0	$0	$0	$0	$2,570	$1,440	$4,010
FT KNOX	$0	$0	$0	$0	$0	$3,260	$3,260
LANDSTUHL	$0	$0	$0	$1,390	$795	$2,470	$4,655
FT DRUM	$0	$0	$0	$0	$0	$2,080	$2,080
FT MONMOUTH	$0	$0	$0	$0	$1,510	$240	$1,750
HEIDELBERG	$0	$0	$0	$0	$2,090	$3,010	$5,100
WUERZBURG	$0	$0	$0	$0	$340	$1,470	$1,810
MEDCOM Total	$83,340	$234,630	$89,180	$90,165	$168,015	$118,560	$783,890


Population Health Portal Logins by Month per Service:
Jan 05 through Aug 06
2500
2000
1500
1000
500
0
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05
Jul-05
Aug-05
Sep-05
Oct-05
Nov-05
Dec-05
Jan-06
Feb-06
Mar-06
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Month
Total Logins USA
Total Logins USAF
Total Logins USN

Promoting Quality and Efficient Health Care in Federal Government Administered and Sponsored Health Care Programs*

- Create incentives for beneficiaries to care about quality and price of their health programs (eg. TMA seeking clarification of Section 1102; CMAC rates published on TMA website)

- Address interoperability of health information technology products (eg. timeline for optimizing AHLTA-VISTA interface)

- Make health information more transparent to consumers (eg. Google HEDIS 2005, AvMed Health Plan)

* **President Bush, Executive Order**

The Eight-Stage Process of Creating Major Change*

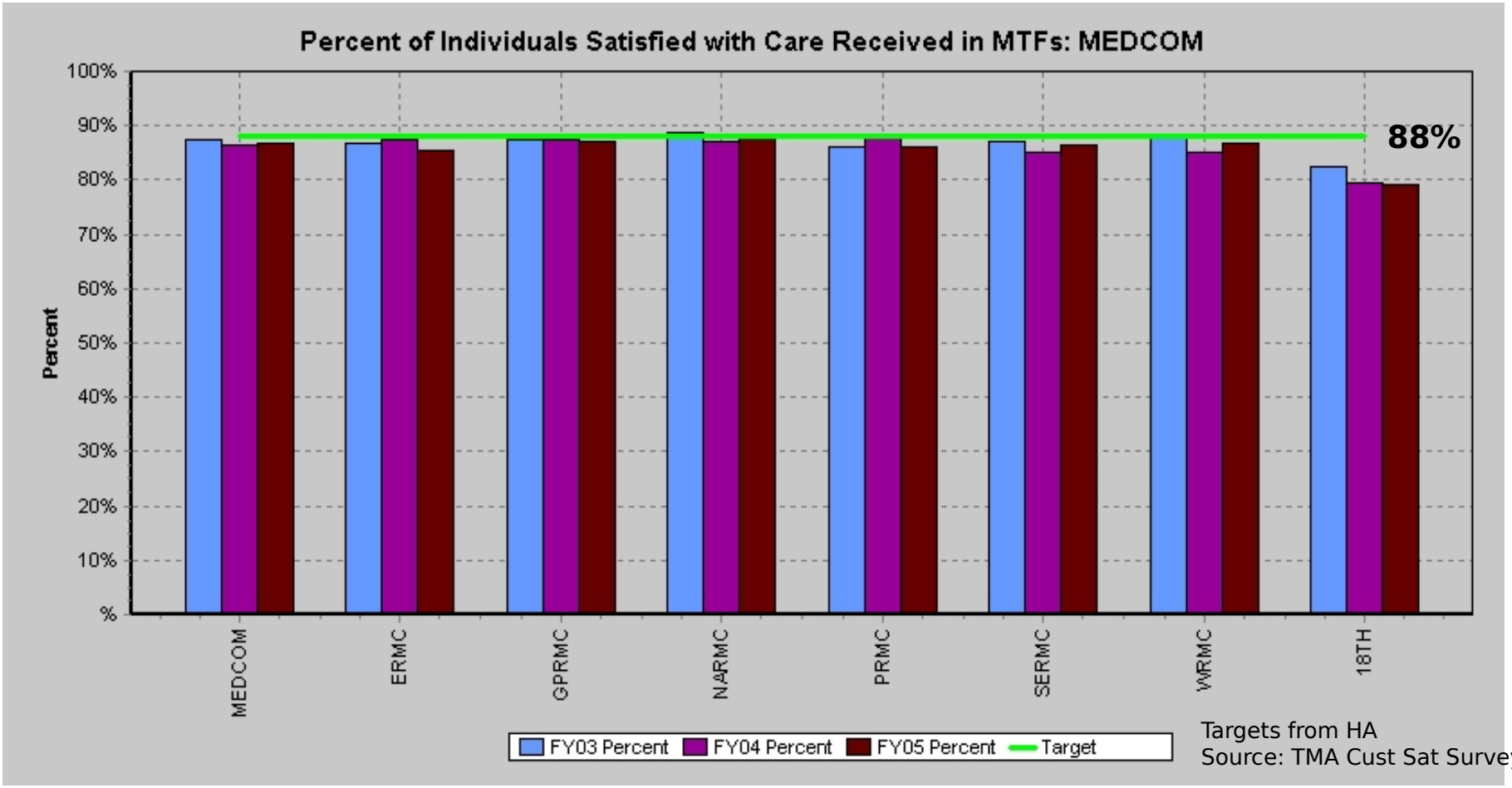
1. Establishing A Sense of Urgency
2. Creating the Guiding Coalition
3. Developing A Vision and Strategy
4. Communicating The Change Vision
5. Empowering Broad-Based Action
6. Generating Short-Term Wins
7. Consolidating Gains and Producing More Change
8. Anchoring New Approaches in the Culture

*Kotter JP. Leading Change. Harvard Business School Press, 1996.

“Redefining Healthcare”*

- “The only way to truly reform health care is to reform the nature of competition”.
- “Mandatory measurement and reporting of results is perhaps the single most important step in reforming the health care system”.
- “Competition on results . . . .”
- “Good quality is less costly because of more accurate diagnoses, fewer treatment errors, lower complication rates, faster recovery, less invasive treatment, etc.”

* **Porter ME, Teisberg EO. Redefining Healthcare. Harvard Business School Press, 2006.**



Targets from HA
Source: TMA Cust Sat Survey

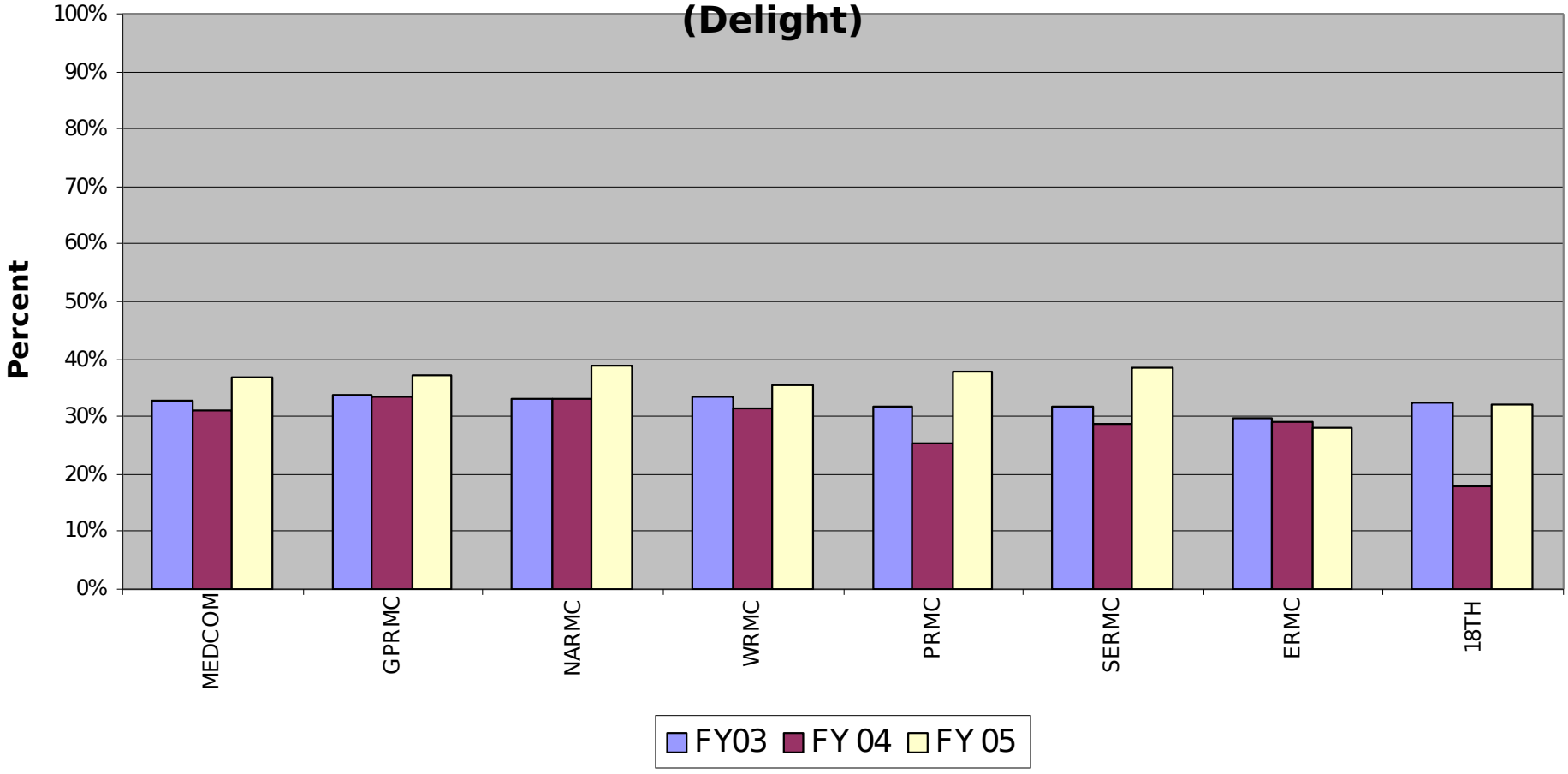
Top 5 Predictors

1. Overall quality of care received
2. Length of time to return call
3. How well care met needs
4. Access to care when needed
5. Personal interest in you and your medical care

Key Points

- Satisfaction is generally high and stable
- Includes 5, 6, & 7 responses on 1-7 scale
- 5: Somewhat satisfied; 6: Very satisfied; 7: Completely satisfied
- VA Sat: 83% inpt; 80% outpt (Source: ACSI)

Satisfaction with Clinic Visit - Top Rating Only
"7s" – Completely Satisfied (Delight)



Key Points

- Completely satisfied members: 37% for FY05
- Noticeable increase from FY04 to 05

Score represents only those members giving a top score of "7" on 1-7 scale

Source: TMA Cust Sat Survey

An AMEDD Organization of Excellence: Actions Must We Take

- Decide what is important.
- Align processes to achieve it. Demand excellence.
- Write policy which aligns with metrics, establish an initial best practice, state the benefit of doing it this way.
- Make data available and display eloquently.
- Share Lessons Learned.

End